



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ZALE LIPSHY
PO BOX 201345
ARLINGTON TEXAS 76006

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-99-1526-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "While the guideline was invalidated due to procedural error and 'fair and reasonable' was not established by the Supreme Court decision, the original suit was brought because the guideline was felt to be a financial hardship on the hospital provider. It is for this reason this billing is resubmitted. We will appreciate your immediate evaluation and response. We understand 100% reimbursement may not be appropriate and will discuss a reasonable settlement."

Amount in Dispute: \$28,849.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills were properly paid pursuant to the per diem rates and other provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline. As described more fully in Exhibit B, the Guideline was developed as a reasonable methodology for fair and reasonable reimbursement for acute care inpatient treatment, while aiming for the cost containment also mandated by the Texas Workers' Compensation Act. While the Guideline was invalidated as a TWCC rule based upon procedural error in its adoption, the per diem rates and methodology of the Guideline remain a valid measure of fair and reasonable reimbursement."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 1997 through May 23, 1997	Inpatient Hospital Services	\$26,849.59	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on May 18, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - T–The payor requests that services covered by this bill be reviewed for medical necessity by healthcare compare, no record of medical necessity review can be found.
 - C–This preferred hospital has contractually agreed to reduce this charge below the usual and customary charges for your business.
 - N–Please submit an invoice of supplies used and a report of time spent to construct the orthotic/prosthetic device
 - C–This document outlines reduction of charges taken as a result of your affordable med net

Findings

1. The carrier denied services using the denial code C “This preferred hospital has contractually agreed to reduce this charge below the usual and customary charges for your business.” And C “This document outlines reduction of charges taken as a result of your affordable med net.” Review of the submitted documentation finds no copy of the contract or documentation to support a contractual agreement between the parties to this dispute. The Division concludes that these EOB denials are not supported. The services will therefore be reviewed per applicable statutes and Division rules.
2. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, requires that “A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute.” The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in *Hospitals and Hospital Systems v. Continental Casualty Company*, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Per 28 Texas Administrative Code §102.3(a)(1), effective January 1, 1991, 15 *Texas Register* 6747, “In counting a period of time measured by days, the first day is excluded and the last day is included.” The request for dispute resolution of services rendered on dates of service May 14, 1997 through May 23, 1997 was received by the Division on May 18, 1998. Review of the submitted documentation finds that the request was submitted more than one year after the date of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that requestor has not met the requirements of §133.305(a). Therefore service dates May 14, 1997 through May 17, 1997 will not be considered in this review. However, the request for dispute resolution of services rendered on May 18, 1997 through May 23, 1997 were submitted in accordance with the timely filing requirements of §133.305(a); therefore, these services will be considered in this review.
3. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission.”
4. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that “Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle.”
5. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include “copies of all written communications and memoranda relating to the dispute.” Review of the documentation submitted by the requestor finds that the request does not include a copy of medical documentation and EOBs or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).

6. Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor's position statement asserts that "While the guideline was invalidated due to procedural error and 'fair and reasonable' was not established by the Supreme Court decision, the original suit was brought because the guideline was felt to be a financial hardship on the hospital provider. It is for this reason this billing is resubmitted. We will appreciate your immediate evaluation and response. We understand 100% reimbursement may not be appropriate and will discuss a reasonable settlement."
- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	November 9, 2011 Date
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_____ Signature	Martha Luevano Medical Fee Dispute Resolution Officer	November 9, 2011 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.